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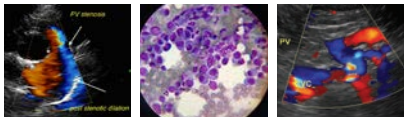

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

8/9/22

PATIENT

Billy Buddenbohn

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

7/1/16

WEIGHT

11.8 Pounds

INTERPRETED BY

Andi Parkinson RDMS

IMAGING PERFORMED BY

Andi Parkinson RDMS

HOSPITAL NAME

Perry Hall AH

REFERRING VET

Dr. Breidenbaugh

INVOICE

40271

PRESENTING CLINICAL SIGNS

P presented for weight loss and decreased appetite on 5/24/22. At this time he was still overweight with a BCS of 6-7/9. Other abnormalities that O noticed at that time: occasional vomiting and sneezing (although no upper respiratory noise ausculted on physical). No pain on palpation. Has lost 4lbs since 3/2022
Lab work reported below. Visited ER on 7/31/22 for blood in stool and was sent home with supportive care. Radiographs showed inflammation of bowel. Continued muscle mass loss. No additional weight loss from earlier in the month.

Current Medications: Supportive care administered post ER visit, will be discontinued by time of ultrasound: probiotic, sucralfate 500mg BID, cerenia 12mg SID. Rx'd gabapentin 100mg for ultrasound to keep P relaxed for imaging.
Lab Results:
5/24/22
CBC: MCH 12.5, low, low retic hemoglobin, mild monocytosis
CHEM: hyperkalemia 5.3, low albumin (2.5), low liver values (ALT 17, AST 14, ALP 11) UA:cysto, usg 1.052, pH 7.5, 2+ protein, trace ketones, negative sediment
T4: 2.2 WNL
fPL: 2.5 WNL

7/15/22
UA: cysto, >1.050, pH 7.0, false ketones, >50rbc/hpf, 1wbc/hpf, NO proteins.

7/19/22
Fecal: NOPS and Ag negative.

7/31/22 (presented to ER for blood in stool) Radiographs (done at ER)- inflammation of intestines FeLV/FIV-Negative.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (4.25 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.17 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect.

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured as normal (between 0.13-0.38cm in wall thickness) and the jejunum measured as normal (between 0.15-0.36cm.) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction is visualized and largely exhibits normal intact wall layering and is subjectively of normal thickness. In close proximity to the ileocecal junction, the large intestine starts to thicken, and the wall appears irregular with complete loss of layering and irregularity, with a maximal thickness of approximately 1.02 cm, most consistent with infiltrative disease to the colon wall, creating a mass effect that is involving over 6 cm of colon. There is inflammation and a lymphadenopathy surrounding the colon.

Pancreas

The pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a significant lymphadenopathy surrounding the colon with lymph nodes measuring 0.83, 0.56 cm in diameter, and hyperechoic mesentery surrounding the colon and lymph nodes.

ULTRASONOGRAPHIC FINDINGS

- Prominent, mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

- Thickened, irregular wall to the colon with complete loss of layering – most consistent with infiltrative disease to the colon. Of primary concern would be neoplasia (round cell neoplasia,

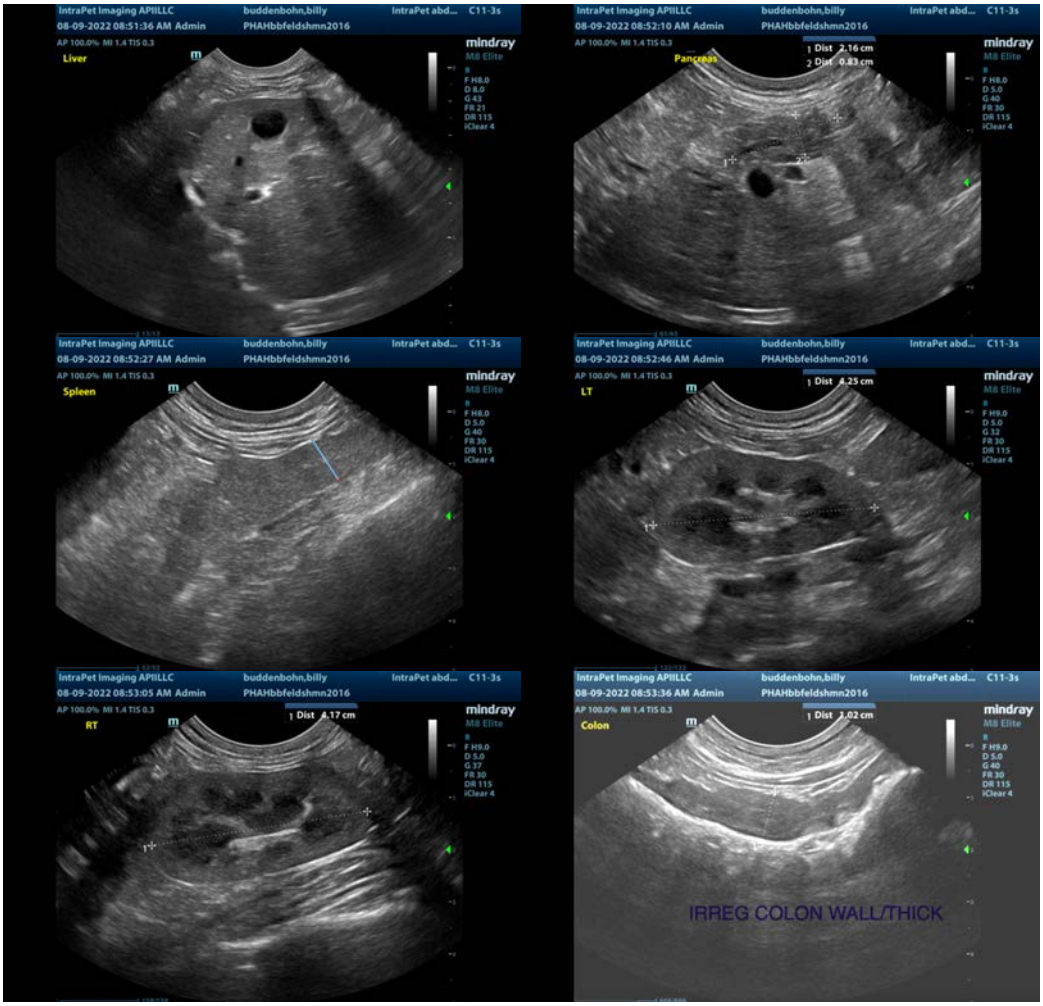
carcinoma, etc.), but infiltrative disease or infectious disease is also possible.

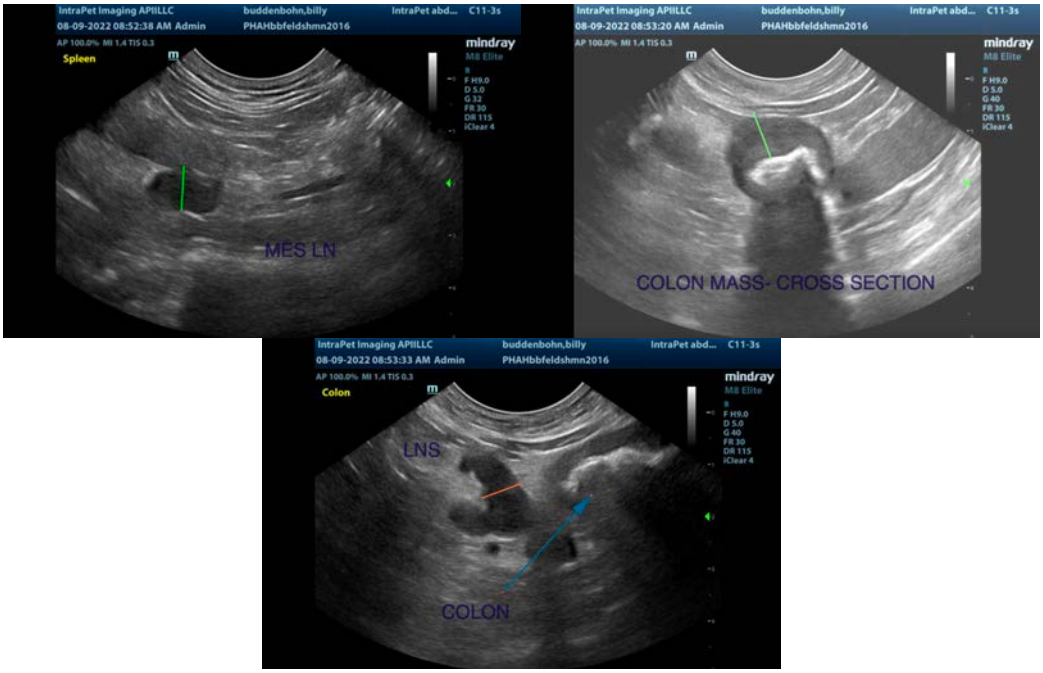
- Mild/moderate mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is an extensive section of colon that has a severely thickened/irregular wall with complete loss of layering. Of primary concern would be neoplasia (round cell neoplasia/carcinoma, etc.), but other inflammatory/infectious diseases can also present like this. Additionally, there is a regional surrounding lymphadenopathy and hyperechoic mesentery. Recommend a fine needle aspirate of the colon wall as well as a fine needle aspirate of a regional lymph node if possible. If a cytologic diagnosis cannot be obtained, you could consider either surgical biopsies or colonoscopy. This is likely the source of the anemia, hypoalbuminemia, and bleeding reported.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.





The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

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